Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

We examined the impact of this notice as required by Executive Order 12866. Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when rules are necessary, to select regulatory approaches that maximize net benefits (including potential economic environments, public health and safety, other advantages, distributive impacts, and equity). We believe that this notice is consistent with the regulatory philosophy and principles identified in the Executive Order. The formula for the allotments is specified in the statute. Since the formula is specified in the statute, we have no discretion in determining the allotments. This notice merely announces the results of our application of this formula, and therefore does not reach the economic significance threshold of $100 million in any one year.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any one year. Individuals and States are not included in the definition of a small entity; therefore, this requirement does not apply.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

The Unfunded Mandates Reform Act of 1995 requires that agencies prepare an assessment of anticipated costs and benefits before publishing any notice that may result in an annual expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $110 million or more (adjusted each year for inflation) in any one year. This notice will not create an unfunded mandate on States, tribal, or local governments because it merely notifies states of their SCHIP allotment for FY 2004 and does not mandate any additional expenditures by these governments. Therefore, we are not required to perform an assessment of the costs and benefits of this notice, in accordance with the Unfunded Mandates Reform Act.

Low-income children will benefit from payments under SCHIP through increased opportunities for health insurance coverage. We believe this notice will have an overall positive impact by informing States, the District of Columbia, and U.S. Territories and Commonwealths of the extent to which they are permitted to expend funds under their child health plans using their FY 2004 allotments.

Under Executive Order 13132, we are required to adhere to certain criteria regarding Federalism. We have reviewed this notice and determined that it does not significantly affect States' rights, roles, and responsibilities because it does not set forth any new policies.

For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this notice will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

(Section 1102 of the Social Security Act (42 U.S.C. 1302))

(Catalog of Federal Domestic Assistance Program No. 93.767, State Children's Health Insurance Program)

Dated: April 2, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: April 29, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–21439 Filed 8–21–03; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2136–FN]

RIN 0938–AL79

Medicaid Program; State Allotments for Payment of Medicare Part B Premiums for Qualifying Individuals: Federal Fiscal Year 2002

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final notice.

SUMMARY: In this notice, we are adopting as final the proposed expenditures allotted under sections 1902(a)(10)(E)(iv)(I) and (II) of the Social Security Act (the Act) to participating State agencies to pay all, or some portion of, Medicare Part B premium costs for a specified category of eligible low-income Medicare beneficiaries called qualifying individuals (QIs) during Federal fiscal year 2002. The proposed notice announcing the update was published in the August 30, 2002 **Federal Register**. Federal fiscal year 2002 is the final year that these allotments are authorized under the Act. However, the Congress has extended funding at the same level for one group of QIs for fiscal year 2003.

EFFECTIVE DATE: This final notice is effective on October 21, 2003.

FOR FURTHER INFORMATION CONTACT: Robert Nakielny, (410) 786–4466.

I. Background

A. Before the Balanced Budget Act of 1997

Before enactment of the Balanced Budget Act of 1997 (BBA), section 1902(a)(10)(E) of the Social Security Act specified that State Medicaid plans must provide Medicare cost-sharing for three groups of eligible low-income Medicare beneficiaries. These three groups include: qualified Medicare beneficiaries (QMBs), specified low-income Medicare beneficiaries (SLMBs), and qualified disabled and working individuals (QDWIs).

A QMB is an individual entitled to Medicare Part A (Hospital Insurance) with an income that falls at or below the Federal poverty level and resources below $4,000 for an individual and $6,000 for a couple. An SLMB is an individual who meets the QMB criteria, except that his or her income is between a State-established level (at or below the Federal poverty level) and 120 percent of the Federal poverty level. A QDWI is an individual who is entitled to enroll in Medicare Part A, whose income does not exceed 200 percent of the Federal poverty level for a family of the size involved, whose resources do not exceed twice the amount allowed under the Supplementary Security Income program, and who is not otherwise eligible for Medicaid.

The definition of Medicare cost-sharing at section 1905(p)(3) of the Act includes payment for Medicare premiums, although QDWIs only qualify to have Medicaid pay their Medicare Part A premiums, and SLMBs only qualify to have Medicaid pay their Medicare Part B premiums.

B. After Enactment of the Balanced Budget Act of 1997

Section 4732 of the BBA amended section 1902(a)(10)(E) of the Act to require that States provide for Medicaid payment of all, or a portion of, Medicare Part B (Supplementary Medical Insurance) premiums, during the period beginning January 1998 through December 2002, for selected members of two eligibility groups of low-income Medicare beneficiaries, referred to as qualifying individuals (QIs).

Under section 1902(a)(10)(E)(iv)(I) of the Act, State agencies are required to pay the full amount of the Medicare Part B premium for selected QIs who would be QMBs except that their income level is at least 120 percent but less than 135 percent of the Federal poverty level for a family of the size involved. These individuals cannot otherwise be eligible for medical assistance under the approved State Medicaid plan.

The second group of QIs, under section 1902(a)(10)(E)(iv)(II) of the Act, includes Medicare beneficiaries who would be QMBs except that their income is at least 135 percent but less than 175 percent of the Federal poverty level for a family of the size involved. These QIs may not be otherwise eligible for Medicaid under the approved State plan, but are eligible for a portion of Medicare cost-sharing consisting only of a percentage of the increase in the Medicare Part B premium attributable to the shift of Medicare home health coverage from Part A to Part B (as provided in section 4611 of the BBA).

Section 4732(c) of the BBA also added section 1933 of the Act, which specifies the provisions for State coverage of the Medicare cost-sharing for additional low-income Medicare beneficiaries.

Section 1933(a) of the Act specifies that a State agency must provide, through a State plan amendment, for medical assistance to pay for the cost of Medicare cost-sharing on behalf of QIs who are selected to receive assistance.

Section 1933(b) of the Act sets forth the rules that State agencies must follow in selecting QIs and providing payment for Medicare Part B premiums. Specifically, the State agency must permit all QIs to apply for assistance and must select individuals on a first-come, first-served basis in the order in which they apply.

Section 1933(c) of the Act limits the total amount of Federal funds available for payment of Part B premiums each fiscal year and specifies the formula to be used to determine an allotment for each State from this total amount. For State agencies that execute a State plan amendment in accordance with section 1933(a) of the Act, a total of $1.5 billion was allocated over 5 years as follows: $200 million in FY 1998; $250 million in FY 1999; $300 million in FY 2000; $350 million in FY 2001; and $400 million in FY 2002.

The Federal matching rate for Medicaid payment of Medicare Part B premiums for QIs is 100 percent for expenditures up to the amount of the State's allotment. No Federal matching funds are available for expenditures in excess of the State's allotment amount. Administrative expenses associated with the payment of Medicare Part B premiums for QIs remain at the 50 percent matching level and may not be taken from the State's allotment.

The amount available for each fiscal year was allocated among States according to the formula set forth in section 1933(c)(2) of the Act.

II. Provisions of the Proposed Notice

The August 30, 2002 (67 FR 55851) proposed notice announced the proposed allotments that were made available to individual States for Federal fiscal year 2002 for the Medicaid payment of Medicare Part B premiums for QIs identified under sections 1902(a)(10)(E)(iv)(I) and (II) of the Act. Specifically, the Federal fiscal year 2002 allotments have been calculated as follows:

A_T = Total amount to be allocated

$M1_i$= 3-year average of the number of Medicare beneficiaries in State i who are not enrolled in Medicaid and whose incomes are at least 120 percent but less than 135 percent of Federal poverty line

$M2_i$ = 3-year average of the number of Medicare beneficiaries in State i who are not enrolled in Medicaid and whose incomes are at least 135 percent but less than 175 percent of Federal poverty line.

Then, the allotment reserved for State i is determined by the following formula:

$$A_i = \left[\frac{2 \cdot M1_i + M2_i}{\sum_j \left(2 \cdot M1_j + M2_j\right)} \right] \cdot A_T$$

We note that the formula used to calculate these allotments is the same we have used since 1998 for calculating the annual QI allotments. In applying the formula for the allotments presented in this document, we have used the latest data available to us as of August 30, 2002, the date we published our proposed allotments for Fiscal Year 2002.

FY 2002 STATE ALLOTMENTS FOR PAYMENT OF PART B PREMIUMS UNDER SEC. 4732 OF THE BBA OF 1997

State	(a) M1[1]	(b) M2[2]	(c) 2 × (a) + (b)	State Share of (c)	State FY 2002 allocation ($000)
AK	1	3	5	0.08%	321
AL	25	68	118	1.90	7,584
AR	23	46	92	1.48	5,913
AZ	20	63	103	1.65	6,620
CA	114	307	535	8.60	34,383
CO	11	37	59	0.95	3,792
CT	11	55	77	1.24	4,949
DC	3	5	11	0.18	707
DE	5	10	20	0.32	1,285
FL	114	249	477	7.66	30,656
GA	31	69	131	2.10	8,419
HI	3	13	19	0.31	1,221
IA	20	49	89	1.43	5,720
ID	7	18	32	0.51	2,057
IL	38	138	214	3.44	13,753
IN	46	88	180	2.89	11,568
KS	12	33	57	0.92	3,663
KY	19	65	103	1.65	6,620

FY 2002 STATE ALLOTMENTS FOR PAYMENT OF PART B PREMIUMS UNDER SEC. 4732 OF THE BBA OF 1997—Continued

State	(a) M1[1]	(b) M2[2]	(c) 2 × (a) + (b)	State Share of (c)	State FY 2002 allocation ($000)
LA	27	57	111	1.78	7,134
MA	40	85	165	2.65	10,604
MD	26	49	101	1.62	6,491
ME	7	23	37	0.59	2,378
MI	42	127	211	3.39	13,560
MN	27	46	100	1.61	6,427
MO	29	60	118	1.90	7,584
MS	17	44	78	1.25	5,013
MT	5	11	21	0.34	1,350
NC	49	89	187	3.00	12,018
ND	5	13	23	0.37	1,478
NE	9	34	52	0.84	3,342
NH	3	14	20	0.32	1,285
NJ	35	109	179	2.88	11,504
NM	11	28	50	0.80	3,213
NV	7	23	37	0.59	2,378
NY	92	233	417	6.70	26,799
OH	52	167	271	4.35	17,416
OK	14	65	93	1.49	5,977
OR	15	32	62	1.00	3,985
PA	81	187	349	5.61	22,429
RI	7	13	27	0.43	1,735
SC	34	58	126	2.02	8,098
SD	4	13	21	0.34	1,350
TN	37	61	135	2.17	8,676
TX	82	218	382	6.14	24,550
UT	7	16	30	0.48	1,928
VA	45	83	173	2.78	11,118
VT	3	8	14	0.22	900
WA	21	56	98	1.57	6,298
WI	24	87	135	2.17	8,676
WV	11	44	66	1.06	4,242
WY	3	7	13	0.21	835
Total	1374	3476	6224	100.00	$400,000

[1] Three-year average (1999–2001) of number (000) of Medicare beneficiaries in State who are not enrolled in Medicaid but whose incomes are at least 120% but less than 135% of the Federal Poverty Level (FPL).

[2] Three-year average (1999–2001) of number (000) of Medicare beneficiaries in State who are not enrolled in Medicaid but whose incomes are at least 135% but less than 175% of the Federal Poverty Level (FPL).

III. Analysis of and Responses to Public Comments and Provisions of the Final Notice

We received no public comments on the August 30, 2002 **Federal Register** proposed notice. We are adopting the provisions of the proposed notice as final.

IV. Regulatory Impact Statement

We have examined the impacts of this final notice as required by Executive Order 12866 (September 1993, Regulatory planning and review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined this notice is not a major rule because we are simply giving notice of FY 2002 allotments that were available to States of up to $400 million for a specialized category of low-income Medicare beneficiaries. We note that these funds were already budgeted and expended. In fact, State expenditures claimed for fiscal year 2002 were less than 25 percent of the total amount allotted, which is below the $100 million threshold for economically significant rulemaking under Executive Order 12866. Therefore, consistent with Executive Order 12866, we are not providing an impact analysis.

The RFA requires agencies to analyze options for regulatory relief for small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity.

This final notice will allocate, among the States, Federal funds to provide Medicaid payment for Medicare Part B premiums for QIs. The total amount of Federal funds available during a Federal fiscal year and the formula for determining individual State allotments are specified in the law. Because the formula for determination of State

allotments is specified in the statute, there were no other options to be considered. Therefore, we have applied the statutory formula for the State allotments except for the use of specified data. Because the data specified in the law were not available, we have used comparable data from the United States Census Bureau on the number of possible QIs in the States, as described in detail in the January 26, 1998 **Federal Register**. Since the statutory formula calls for an estimate of individuals who could qualify for QI status rather than the number of individuals who actually have that status, the exact numbers of those individuals will always be uncertain. These new allotments for FY 2002 incorporated the latest data from the United States Census Bureau from 1999 to 2001, as specified in the footnotes to the preceding table.

We believe that announcing the final allocations in this notice will have a positive effect on States and individuals. Federal funding at the 100 percent matching rate was available for Medicare Part B premiums (or for a portion of those premiums) for QIs.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or any the private sector, of $110 million. This final notice does not mandate expenditure by State, local or tribal governments in the aggregate or the private sector of $110 million.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications.

Because this final notice provides notice of funding ceilings, as determined under the statute, we have determined that this final notice will not significantly affect the rights, roles, and responsibilities of States.

We are not preparing analyses for either the RFA or section 1102(b) of the Act, because we have determined, and we certify, that this final notice will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this final notice was reviewed by the Office of Management and Budget.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: April 18, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: May 13, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–21440 Filed 8–21–03; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4053–N]

Medicare Program: Meeting of the Advisory Panel on Medicare Education—September 18, 2003

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice of meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act, 5 U.S.C. Appendix 2, section 10(a) (Public Law 92–463), this notice announces a meeting of the Advisory Panel on Medicare Education (the Panel) on September 18, 2003. The Panel advises and makes recommendations to the Secretary of the Department of Health and Human Services and the Administrator of the Centers for Medicare & Medicaid Services on opportunities to enhance the effectiveness of consumer education strategies concerning the Medicare program. This meeting is open to the public.

DATES: The meeting is scheduled for September 18, 2003 from 9:15 a.m. to 4 p.m., e.d.t.

Deadline for Presentations and Comments: September 11, 2003, 12 noon, e.d.t.

ADDRESSES: The meeting will be held at the Wyndham Washington Hotel, 1400 M Street, NW., Washington, DC 20005, (202) 429–1700.

FOR FURTHER INFORMATION CONTACT: Lynne Johnson, Health Insurance Specialist, Division of Partnership Development, Center for Beneficiary Choices, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, mail stop S2–23–05, Baltimore, MD 21244–1850, (410) 786–0090. Please refer to the CMS Advisory Committees' Information Line (1–877–449–5659 toll free)/(410–786–9379 local) or the Internet (*http://www.cms.hhs.gov/faca/apme/default.asp*) for additional information and updates on committee activities, or contact Ms. Johnson via e-mail at *ljohnson3@cms.hhs.gov.* Press inquiries are handled through the CMS Press Office at (202) 690–6145.

SUPPLEMENTARY INFORMATION: Section 222 of the Public Health Service Act (42 U.S.C. 217a), as amended, grants to the Secretary of the Department of Health and Human Services (the Secretary) the authority to establish an advisory panel if the Secretary finds the panel necessary and in the public interest. The Secretary signed the charter establishing this Panel on January 21, 1999 (64 FR 7849), and approved the renewal of the charter on January 21, 2003. The Panel advises and makes recommendations to the Secretary and the Administrator of the Centers for Medicare & Medicaid Services (CMS) on opportunities to enhance the effectiveness of consumer education strategies concerning the Medicare program.

The goals of the Panel are as follows:

- To develop and implement a national Medicare education program that describes the options for selecting a health plan under Medicare.
- To enhance the Federal government's effectiveness in informing the Medicare consumer, including the appropriate use of public-private partnerships.
- To expand outreach to vulnerable and underserved communities, including racial and ethnic minorities, in the context of a national Medicare education program.
- To assemble an information base of best practices for helping consumers evaluate health plan options and build a community infrastructure for information, counseling, and assistance.

The current members of the Panel are: Dr. Jane Delgado, Chief Executive Officer, National Alliance for Hispanic Health; Joyce Dubow, Senior Policy Advisor, Public Policy Institute, American Association of Retired Persons (AARP); Clayton Fong, President and Chief Executive Officer,